

Marie Curie

Marie Curie Hospice Bradford

Inspection report

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29 September 2016

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

The inspection was carried out on 13 & 29 September 2016. The visit on 13 September 2016 was unannounced which meant the provider and staff did not know we would be visiting. We informed the provider we would be visiting on 29 September 2016.

The last inspection took place in January 2014 and at that time the service was compliant with the regulations inspected.

The hospice offers specialist care for people with cancer and other life-limiting illnesses and support for families. The hospice has a 16 bed in-patient unit and also provides day services. The day services did not form part of this inspection. On 13 September 2016 there were 15 people receiving care and treatment on the in-patient unit.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Everyone we spoke with told us they felt the hospice was a safe place where they were cared for by caring and competent staff. There were systems in place to make sure people were safeguarded and staff knew how to recognise abuse and how to report any concerns about people's safety and welfare.

The recruitment procedures were robust and all the required checks were completed before new staff started work. This helped to protect people from the risks of receiving care, support and treatment from staff unsuitable to work with vulnerable adults.

The hospice employed a range of medical and nursing staff and health and social care professionals such as social workers. There were enough staff to ensure people received the right care and treatment and without exception people told us staff responded promptly to their changing needs. Staffing numbers and skill mix were reviewed to ensure they remained appropriate to people's needs.

People's medicines were managed safely and symptom control and pain relief was available at all times during the day and night.

We found risks to people's health, safety and welfare were well managed. People's care records included information about individual risks and how these were managed.

The hospice was clean and well maintained and equipped to meet people's needs. Checks were carried out on equipment and installations which helped to ensure the premises were safe for people to use. There were clear systems and processes in place to deal with emergencies, both medical and non-medical

emergencies.

Incidents and accidents were recorded and reviewed and whenever possible action was taken to reduce the risk of recurrence.

People told the staff were well trained and had an air of confidence which they found reassuring. We found staff were supported to continue to develop their knowledge and skills and to deal with the emotional challenges of their work.

The management and staff showed us they had a good understanding of their responsibilities in relation to The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This helped to make sure people's rights were protected and promoted. However, this was not always reflected in the records where we found mental capacity assessments and best interests' decisions were not clearly documented.

People were offered a choice of food which took account of their ethnic, cultural and dietary needs and preferences. We found the catering staff were committed to doing whatever they could to accommodate people's requests. Although nutritional assessments were not being carried out routinely at the time of the inspection people received support from dieticians and speech and language therapists where necessary.

People were supported to maintain their wellbeing by a multi-disciplinary team. People spoke very highly about the nursing and medical staff, they said communication was excellent and this helped them to understand what was happening.

Without exception people told us the staff were very caring. They told us the staff were excellent and talked about staff who had a passion for their work. Care and support was person centred and people's choices were respected. People's privacy, dignity and cultural diversity were respected.

People told us they were fully involved in decisions about the care and treatment. Families and carers were supported when people were receiving care and treatment and after bereavement. Staff showed a good understanding of people's individual needs and preferences and spoke fondly about the people in their care.

Without exception people told us the hospice was responsive to their individual needs and responded quickly to their changing needs. We found people had access to complementary therapists but this was only provided by volunteers and therefore may not always be available when people needed it.

People told us they knew how to make a complaint if they needed to. Complaints were taken seriously and we saw an example of how a complaint had been used to make improvements to the service.

People were supported to share their views of the service.

There were systems and processes in place to monitor and assess the safety and quality of the services provided. We found the management team was open and promoted a culture of continuous improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People were protected from harm. Staff were trained and understood their safeguarding responsibilities. The required checks were carried out before new staff started work to ensure they were suitable to work with vulnerable people.

There were enough staff with the right skills and expertise to meet people's needs.

People's medicines were managed safely.

The hospice was clean, well maintained and well equipped. It was light and airy and people had easy access to the patio and gardens.

Risks to people's safety and welfare were managed.

Is the service effective?

Good ●

The service was effective.

People received care and treatment from a team of well-trained, competent and confident staff.

People, their families and carers were involved in making decisions about their treatment and care needs and received support to manage their symptoms.

People's dietary needs and preferences were catered for.

People's rights were protected. The service was working in accordance with the principles of Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Is the service caring?

Good ●

The service was caring.

Without exception people spoke in glowing terms about the staff, describing them as caring, compassionate and always willing to

do whatever they could to make people comfortable.

People were treated as individuals, their privacy, dignity and cultural diversity was respected.

People were involved in making decisions about all aspects of their current and future care and treatment.

Is the service responsive?

Good ●

The service was responsive.

People experienced care and treatment which was responsive and adapted to meet their individual needs.

Complementary therapies were provided by volunteers and therefore may not always be available when needed.

People's concerns and complaints were taken seriously and acted on. Complaints and concerns were viewed as an opportunity to improve the service.

Is the service well-led?

Good ●

The service was well led.

The management team was highly motivated; there was a culture of openness and a clear commitment to continuous improvement.

The provider had effective systems in place to monitor and assess the safety and quality of the services provided.

People who used the service, their family and carers were given opportunities to say what they felt about the service and to make suggestions for improvements.

Marie Curie Hospice Bradford

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 13 and 29 September 2016. The visit on 13 September 2016 was unannounced. We informed the provider of our visit on 29 September 2016.

Before the inspection we reviewed the information we held about the service, this included notifications of significant changes or events. We contacted Healthwatch and the local Clinical Commissioning Groups (CCGs) to ask for their views of the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The registered provider completed a provider information return (PIR) prior to the inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We took this information into account when making our judgements.

The inspection was carried out by two adult social care inspectors, a pharmacy inspector, a specialist advisor in palliative care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case palliative care services.

During the inspection we spoke with six people who used the service and 12 relatives. We looked at three people's care records and three people's medication records. We looked at other records related to the day to day running of the service such as staff files, training records, maintenance records, meeting notes, survey results and audits. We looked around the communal areas and some bedrooms.

We spoke with various staff including the registered manager, the clinical lead nurse, the service development lead, the ward sister, two nurses, a health care assistant, a specialist palliative care doctor, the principle social worker, an occupational therapist, the chef and the facilities manager.

Is the service safe?

Our findings

We asked people if they felt safe at the hospice and their replies were overwhelmingly positive. They told us they felt relieved to be in "Safe hands" and cared for by staff who had training, expertise and a passion for their work.

One person described their experience of coming to the hospice by saying, "It's like being rescued, having a big blanket wrapped around you." Other comments from people included, "They [staff] fully understood exactly how I was feeling." "They [staff] know how to manage my condition, I feel safe." "I feel safe, the staff glow with confidence, I know what to expect." "I feel very, very safe. The people here make you feel safe they are so reassuring."

The provider had policies and procedures in place about safeguarding adults and children. The hospice did not provide care and treatment directly to children but the nature of the services provided meant they often had indirect involvement with children. The principle social worker was the safeguarding lead for the service and they explained how they worked with the local authority, and if necessary the police, when any safeguarding concerns were identified. The records we hold about the service showed us that since the last inspection they had identified and dealt with any safeguarding concerns in an appropriate way.

Staff received training on safeguarding adults and children and understood their responsibilities in relation to keeping people safe from harm. This demonstrated the provider had suitable arrangements in place to protect people from harm and should abuse take place to reduce the likelihood of it going unnoticed.

We asked people if they felt there were enough staff to look after them. Without exception they told us they felt the staff knew what they were doing and reacted in a very timely manner to their ever-changing needs. They told us staff responded quickly and in some cases pre-empted need. For example, one person said, "Sometimes they pop their heads into my room and say you haven't rung your bell for a while, are you OK?" Another person said, "I ring the bell and they come, can't fault them."

We discussed staffing with the senior management team. They told us staffing numbers and skill mix were identified using a workforce planning tool. At the time of the inspection the usual staffing levels on the in-patient unit were four nurses and three health care workers during the day. In the evening there were three nurses and two health care workers, one of whom worked at twilight shift from 3 or 4pm to 11pm or mid-night. Overnight there were three nurses and one health care worker. The clinical lead nurse told us staffing levels had recently been reviewed and they had the right staffing arrangements in place to deliver the service. We spoke with the ward sister who told us the hospice was a good place to work. They said, "We have a good team, open to changes and improvements." They said they were well supported by the senior management team.

The provider had robust recruitment procedures in place for the employment of new staff. Prospective staff members were asked to complete an application form covering areas such as their previous experience and qualifications and a full employment history. Pre-employment checks were carried out, which included

requesting and receiving written references and checks with the Disclosure and Barring Service (DBS). DBS checks were carried out to confirm whether prospective new care workers have a criminal record or have been barred from working with vulnerable people. Checks were also completed regarding professional registration and qualifications for example for nursing and medical staff.

We looked at the way medicines were managed within the hospice. One person who used the service told us, "They [staff] sorted out all my medication, I can't fault them."

There were clear, comprehensive and up to date policies and procedures covering all aspects of medicines management.

We looked at how medicines were handled on the ward and saw appropriate arrangements were in place for checking and confirming people's medicines on first admission to the hospice. When people were discharged, we saw that detailed information about their current medicines; including changes made during their stay in the hospice were communicated to their doctor. This helped to ensure up to date information about people's medication was available to their GPs.

We saw that a lockable cabinet was located in each bedroom for the secure storage of medicines. Staff told us that no one was managing their own medicines and that people were not routinely asked if they wanted to manage their own medicines on admission to the unit. At the inspection we found that one person was self-administering one inhaler, however the appropriate risk assessment had not been completed.

Appropriate arrangements were in place for the recording of medicines. The medication records we checked showed people received their medicines as prescribed. For a medicine that staff administered as a patch, a system was in place for recording the application and removal of the patch.

Medicines were kept safely and securely and only accessible to staff authorised to handle medicines. Medicines were stored at the correct temperature and therefore were suitable for use. There was a system in place for checking expiry dates of medicines. Controlled drugs were ordered, received, stored, checked and disposed of in accordance with the required legislation.

Nursing staff told us that they received training in medicines management and specialist equipment such as syringe drivers. Their competency for administering medicines was assessed at regular intervals.

Arrangements were in place to ensure that medicines incidents were reported and fully investigated and we found there was an open culture around reporting medicine errors. All the staff members we spoke with were aware of how to report any medicines incidents. All the errors reported had been investigated and actions put in place to reduce the risk of them re-occurring. There was a system to receive and act upon national drug safety alerts.

This demonstrated people were protected against the risks associated with medicines because appropriate arrangements were in place to manage medicines.

We looked at the how risks to people's health, safety and welfare were managed within the hospice.

Staff demonstrated to us they were knowledgeable about the level of risk related to the people they were caring for. Regular multi-disciplinary meetings took place on site to discuss and review the rapidly changing care needs of people using the hospice. We saw risk assessments were in place for falls, moving and handling and skin integrity. Records showed that risks were updated and reviewed regularly. The falls risk

assessment required the staff member completing this to answer six questions about cognitive impairment, medicines and health. Staff then made a decision if people were low risk, at risk or high risk. However, the records we reviewed failed to clearly demonstrate how the staff member had calculated their decision about the level of risk.

The hospice had an information booklet for people, carers and relatives on reducing the risk of falls. This provided useful information about the measures people could take to reduce their risk of falling. Other risk assessments contained limited information and were not individual to the person. This meant staff didn't always have the written guidance to keep people safe. We pointed this out to the management team who told us they had already identified this and were in the process of reviewing risk assessments.

We spoke with the occupational therapist who told us they were assessing risks to people on a day to day basis. They told us that for some people they would complete an environmental risk assessment of the person's home and the person before discharge home. The occupational therapist told us how they made sure any adaptations such as the installation of a stair lift or the fitting of a temporary ramp to allow access to the person's home were completed in a timely way. They told us how equipment such as commodes, raised toilet seats and specialist beds were ordered prior to discharge. This helped to ensure a smooth transition from the hospice environment to home.

We looked around and found the hospice was clean, well maintained and suitably equipped to meet people's needs. The bedrooms were on the ground floor and all but one had direct access to the patio and gardens with doors which were wide enough to allow beds to be pushed outside.

The maintenance records showed regular health and safety checks were carried out to help keep the premises safe for people to use. These included checks of fire safety, gas and electrical safety, water safety and emergency lighting. The records confirmed specialist equipment, such as hoists were serviced regularly.

The service had a business continuity plan which gave details of the actions to be taken to continue the operation of the service in the event of an emergency. The plan clearly documented the contingency plans to manage any of these situations. The facilities manager told us they carried out a minimum of four testing exercises a year in addition to four fire drills. This was confirmed by the records. The facilities manager told us at least one of the four fire drills was done outside of normal office hours. They told us a recent out of hour's fire drill had identified some weaknesses in the system and as a consequence changes had been made to the fire procedures. These changes were being implemented at the time of the inspection. They included linking the fire alarm to an external monitoring service who would call the fire brigade automatically unless instructed otherwise by the service.

Staff were trained to deal with medical emergencies and the necessary equipment was easily available.

The hospice had several governance groups which all fed into the senior management team. This included an environment and risk group which took the lead in dealing with matters relating to the premises and risks to people's safety and welfare. There was a generic risk register in place, risks were rated using a RAG (Red, Amber, Green) system and any high risk areas were identified and discussed.

The provider had a robust system of incident and accident reporting. All incidents and accidents were logged onto a computer based system which provided an overview of incidents and any actions required to prevent the situation happening again. There were checks built into the system to ensure incidents received the required scrutiny from senior managers. This included a weekly incident meeting to help make sure potential issues or themes were identified and dealt with quickly and to discuss any actions from previous

incidents.

Is the service effective?

Our findings

All the people we spoke with said they felt the staff knew what they were doing and reacted quickly to their changing needs. Several people we spoke with said the staff had an air of confidence which they found reassuring.

Nationally the provider had a Learning and Development Strategy which set out the framework for staff training, development and support over the next three years. Newly appointed staff received induction training and mentoring for the first three to six months of their employment. Thereafter they were supported to develop their skills and knowledge by means of one to one supervisions, appraisals, reflective meetings and a planned training programme. Training was delivered in a variety of ways such as formal classroom sessions, informal discussions and presentations and on-line.

The registered manager told us all staff appraisals were up to date and the staff we spoke with told us they felt well supported and had ample opportunities for training and development. The training matrix provided information on the training staff were required to complete and the frequency of updates. This included subjects such as moving and handling, infection control, fire safety, basic life support, safeguarding, data protection and equality and diversity.

The hospice had several link nurses who networked nationally within Marie Curie and locally with other services to help make sure they kept up to date with current best practices. These included areas such as infection control, tissue viability and dementia champions. We talked with the tissue viability link nurse who spoke enthusiastically about their role and told us about the training they had provided for staff and how this had improved people's care.

The hospice had introduced the nationally recognised practice of 'Schwartz' rounds earlier in the year. 'Schwartz' rounds provide a safe and supportive environment within which staff of all disciplines can reflect on their own feelings, experiences and the emotional challenges of caring for people. The clinical lead told us staff found them helpful and they had been well attended. However, the minutes of the senior managers meetings showed the rounds had been suspended for three months for operational reasons.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection there had been two applications made to deprive people of their liberty. The management team and staff had received training on MCA 2005 and DoLS and were very knowledgeable and demonstrated a good

awareness of the code of practice.

Individual care records indicated that attention was paid to making sure that people were supported to give consent and make decisions about their care and treatment. We saw examples when people were supported and involved in decisions such as if they wanted to be resuscitated in case of a cardiac arrest. This meant that people were enabled to make informed choices and decisions regarding their life and treatment.

We looked at the care records of one person and saw that staff had carefully assessed the person's capacity over a number of days, however capacity assessments were not decision specific and best interest decisions were not clearly recorded within the plan of care. We spoke with the management team who were aware of the need for improvement in this recording.

During the inspection we spoke with the chef who told us people were supported to enjoy their food and were offered choice and variety, which respected people's ethnic, cultural and dietary requirements. People were consulted regarding their preferences and choice of food. We were told and saw that a chef visited the ward at least twice a day to speak with people about what they would like to eat that day. The chef showed us menus that provided choice at each meal time. They told us that all soups were made with fresh cream and that one person had enjoyed the soup so much they had asked for the recipe on discharge from the hospice.

The chef told us how they were committed and would go the extra mile to make sure they accommodated people's individual requests or needs. They said, "We make a difference, we get people to eat who haven't eaten." The chef also told us how they could accommodate special diets such as renal, diabetic and coeliac and how if needed food and drink could be liquidised or thickened.

Within the hospice there was also a canteen which was accessible to people who used the service, relatives and staff. People who used the service did not have to pay for this facility. Staff told us the canteen provided people with the opportunity to spend time with their family.

At the time of the inspection people were not routinely nutritionally assessed, however staff told us they worked closely with dieticians and speech and language therapists to ensure people's needs were met. People had a plan of care for nutrition.

People who used the service confirmed their preferences and needs were catered for. One person said, "My appetite is waning and they give me small meals just as I like them, it's not the quantity is the quality."

People were supported to maintain their health and had access to other healthcare services. Specialist advice and support for people's care, symptom control and pain relief was available at all times during the day and night. The hospice employed a range of staff, this included nurses, healthcare assistants, doctors and a palliative care consultant. Medical cover was provided on a daily basis during the hours of 9am and 5pm and after that time there was an on call rota in which nursing staff could contact the doctor for advice or if needed a visit. A physiotherapist and occupational therapist were contracted on a service level agreement with the acute trust to work with people who used the service.

The relatives we spoke with during the inspection spoke very highly about the nursing and medical staff. One relative said, "All of the staff including the nurses and doctors are brilliant. All staff have an air of confidence and are so knowledgeable. Communication is first class we are very clear on what is happening." Another relative said, "The doctors and nurses are great." Another person told us they could see the doctor

whenever they needed to adding, "They go above and beyond."

Is the service caring?

Our findings

Without exception people who used the service said the staff were extremely caring. They said staff took the time to get to know them well and one person illustrated this by telling us, "They know what you need before you do sometimes." Other comments from people who used the service included: "They [staff] always have a smile on their faces." "Staff are excellent, all staff are experienced and love what they are doing, they are dedicated." "They must have a passion for this type of work." "They [staff] are respectful of all cultures."

All the relatives we spoke with told us they were very happy and said the staff were extremely caring. One relative said, "They [staff] make you feel part of what's happening, not just an outsider looking in." Other comments from relatives included, "They make you feel like you matter just like the person you are coming to see." "They will bring you a cup of tea, that's caring for the relatives." "When they talk to my Dad they talk to him as a person not as a number or symptom. They [staff] call him by his preferred name. They don't rush; they take time to talk to him and make eye contact and actually listen."

The provider told us, "The patient is at the centre of everything we do. Patients are supported to have difficult conversations and explore advanced care planning." During the inspection we talked with people about how this approach influenced their experiences of care at the hospice. People who used the service and relatives all told us they were given choices and involved in decisions about their care and treatment. For example, one person said, "I'm involved with my care planning, they respect my dignity, always ask me before doing anything. I can wander into the garden if I want, it's my decision." Another person said, "They [staff] talk to you and explain what might happen, it helps to plan."

We saw staff provided people with choices throughout the day such as the actual time they needed help with personal hygiene. One person had chosen not to get washed first thing in the morning but was to have a bath later in the day. People decided when they wanted to get out of bed, when and what they wanted to eat. Another person told us "I can have a bath, Jacuzzi, whatever I want and they look after my dignity." A third person said, "I really fancied some peanut butter and cheese sandwiches and the next day they had got some peanut butter for me."

The provider told us the staff team were fully aware of all advocacy services and referred people for support when needed. None of the people using the service at the time of the inspection required an advocate.

The service recognised the significance of family during this difficult time. People's family members and friends were able to visit at any time. One person said, "It's like home from home." In addition facilities were available for relatives to stay overnight. A relative told us they and the extended family were always made to feel extremely welcome and that they were very grateful that they were able to stay in the relative's accommodation and be close to the person who used the service.

There was a large communal area, which throughout the day was well used and staff told us it had also been used to host celebrations such as weddings and christenings. Staff also told us on one occasion a person's

bed had been moved in there so that they could see the sky in their final hours and moments before death. The person had expressed a wish to be outside under the stars when they died. However, as the approached the end of their life the weather made it impossible to go outside and as an alternative staff had suggested moving their bed into the communal room so that they could see the sky through the glass roof.

Staff spoke fondly and were knowledgeable about the people they cared for. They showed a good understanding of the individual choices, wishes and support needs of people within their care. All were respectful of people's needs and described a sensitive and compassionate approach to their role. Staff told us they enjoyed their work because everyone cared about the people they supported. One staff member told us, "I love my job; I find it a very privileged position to be in." Another staff member said, "I love working here. As soon as you come through the door you can tell that people care."

Everyone we spoke with told us their privacy and dignity was respected. This was confirmed by our observations and by results of a survey carried out by the provider. The survey showed the hospice had scored 97.35% on privacy and dignity based on responses from 113 people. In the same survey just over 90% of the people who responded said they would recommend the service to family and friends.

In addition, we saw that in August 2016 there were sixteen compliments in the form of 'Thank You' letters and cards, from people who used the service, their families and carers. They all contained positive comments and commended staff for their supportive and helpful attitude to people who used the service and their families and carers. A common theme was that "Nothing was too much trouble."

The service had a beautiful multi faith chapel in which there was an area designated to memories of those people that had died. The hospice had a 'Patient and Family Support Team' made up of social workers and Chaplains. In addition to supporting people with their social needs, for example by advising on benefits and housing, the team provided spiritual and emotional support. One example of this was supporting people to make memory boxes or memory books. The team also provided post bereavement support to families and carers. This started with a meeting after death to support people with the practicalities of registering the death and arranging the funeral and was followed up with letters offering people additional one to one support.

Families and carers also had the opportunity to attend memorial services if they wished. The hospice organised four memorial events throughout the year. Historically these had always taken place at the hospice, however, the principle social worker told us the April 2016 memorial had been taken place at an external venue. This had been done to encourage more people to attend and to raise awareness of the hospice within the local community.

The provider told us they recognised the diverse culture of the community they served and had access to an ethnic liaison officer. They told us they managed the various facets of cultural diversity. For example, they provided a separate prayer room and washing facilities for people of the Muslim faith.

Staff received cultural awareness training and this included 'myth busting'. The clinical lead nurse told us this training had been very helpful. Within the incident records we saw an example of how staff had supported someone whose first language was not English. During the night the person had fallen. Staff called an interpreter to explain what they needed to do to help the person back to bed. This involved the use of equipment and staff had asked the interpreter to stay on the line until the person was safely back in bed. This had helped to allay the person's anxieties.

Nationally the provider, Marie Curie in partnership with Kings College London and The University of London,

had undertaken research into the real experiences of end of life care for LGBT people. The report called "Hiding who I am" included a number of commitments by the provider to improve the end of life experiences of LGBT people. At the time of our inspection the provider had started to have discussions with local services, such as the Bradford hospice, about how these commitments could be put into practice. Therefore, I was too soon to assess if this was making a difference to the experiences of people who used the service.

Is the service responsive?

Our findings

People and their relatives told us the hospice was responsive to their needs. For example, one person said, "They know me and know before I need things, they give me pain relief when it's needed." A visitor said the care was excellent and adapted to their relative's needs. They cited examples of being able to take the bed outside and being able to bring pets to visit, "We brought our dog in and Dad loved seeing him."

People were referred to the hospice by a range of professionals, including GP's, members of the palliative care team, and hospital and community teams. Staff told us the average length of stay at the hospice for symptom management was 10 to 14 days and then people would return home. The inpatient unit also provided end of life care.

We reviewed the assessment and care planning documentation for three people who were or had used the hospice. People and relatives told us they had been fully involved in drawing up the plan of care and making decisions.

We noted the system of planning people's care included the use of 'core care plans'. These were pre-printed care plans into which the person's name was added. There was scope for individualising these care plans, by the addition of extra information unique to the person, but most of the care plans we looked at contained minimal individual information about the person. The core care plan included general care to be provided to people. For example, we looked at the mouth and oral care for one person who used the service. The core care plan informed to support with mouth care twice daily but doesn't state what the actual mouth care was. Another care plan for personal hygiene informed the person like to be washed whilst in bed, but didn't state what actual support was needed. Another care plan for variable moods and aggression informed the person was soothed by visits from their family but didn't detail the action staff were to take if the person became aggressive. We discussed care plans with the management team who told us they were in the process of reviewing care plan documentation and would meet with staff to ensure time was taken with care planning to ensure it was person centred and reflected the high level of quality care and support that was provided.

Complementary therapy was provided by volunteers who worked on three days and two evenings. The hospice did not employ any complementary therapists and at the time of the inspection there were no plans to do so. The volunteer complementary therapists also covered the day hospice which potentially had an impact on people receiving care and treatment on the in-patient unit. For example, on the day of inspection there was only one therapist, they were working in the day hospice and did not go onto the inpatient unit.

The hospice provided day services and people on the in-patient unit were welcome to join in activities in the day unit. We saw information about activities was displayed. The hospice also had volunteer befrienders who were available to provide support to people.

People told us they could complain to the staff who were caring for them if they needed to. One person said, "I feel that I can say if things aren't right but they are so it's no problem."

Information about the complaints procedure was available and there was a comments book in reception where people could provide feedback.

The hospice had received three complaints in the last 12 months. The records showed complaints were recorded and dealt with in line with the provider's policy and procedures. The registered manager told us one of the complaints had identified some weaknesses in the discharge planning pathway and as a result changes had been made. For example, the provider had changed some of the wording in the information booklet, 'What to expect from your hospice' to make it clearer what happened when people were discharged. This showed us the provider had taken people's concerns seriously and viewed complaints as an opportunity to improve the service.

The service also kept a record of compliments. They had received 85 in the past 12 months. The provider told us the compliments mainly focussed on the quality of care, the kindness, compassion and respect people experienced from all the staff and how the service made people feel safe and secure.

Is the service well-led?

Our findings

The registered manager for Marie Curie Bradford had left the hospice at the end of August 2016 to take up another post within the organisation. At the time of our inspection the registered manager from the Marie Curie hospice in Newcastle was providing management support. Since our visit they have been registered by the Commission as the manager for the Bradford as well as Newcastle. This is a temporary arrangement to ensure continuity until such time as a new manager is appointed for the Bradford hospice. The provider has started the process of recruiting a new manager.

We found the hospice was organised and well managed. There was a hierarchy of care roles but we observed staff worked together as a team and carried out their duties in calm manner. People who used the service told us they thought the hospice was well run but were unsure of who the manager was. One person said, "I have not seen the big wigs, I see those that care for me and don't need to know the bosses as long as they do their job".

The provider, Marie Curie, has a clear vision and this and other information about the providers approach to care is available on their website. The management team were aware of the vision and strategy and promoted a positive culture which was person centred, inclusive and committed to continuous improvement. We found many examples of this during the inspection as detailed throughout this report.

In our discussions with the senior management team we found they were passionate about providing the best possible care to people. In addition, they were committed to promoting hospice services to wider groups of people who may not traditionally have had easy access to hospices, for example, people living with dementia. To support this aim all staff had undertaken training on dementia awareness and the hospice was using 'My Life' software to help people create books containing detailed information about their life history to help staff understand their current needs.

The provider sought feedback from people who used the service in variety of ways. There were suggestion boxes and cards around the hospice for people to use. Trained volunteers were used to gather real time feedback, which was collected electronically on a tablet. This was reviewed centrally and if a questionnaire scored below 90% the hospice was informed and contacted the person immediately to try to resolve the matter as quickly as possible.

The provider also had a national 'Expert Voices Group' which gave people the opportunity to have a say in how the services were designed and delivered.

There was a clearly defined management structure and well established processes for monitoring and assessing the safety and quality of the services provided. There was a quality group which took the lead on clinical audits and provided a platform for all staff to attend and take turns in presenting audit results and information about service improvements. There was an audit schedule which included topics such as governance, documentation, medication, controlled drugs, rehabilitative palliative care and health and safety. In addition, the provider's quality assurance team carried out an annual internal inspection using the

Care Quality Commission Key Lines of Enquiry to benchmark for service improvements.

There were numerous audit groups in the hospice as well as local, regional and national steering groups. This included the senior management team/governance meetings which took place every six weeks. In addition, the senior management team had weekly 'catch up' meeting to ensure any new issues were identified and dealt with in a timely way and to monitor progress on actions agreed at the six weekly meeting.

Any areas for improvement which we identified during our inspection had already been identified by the provider and were being addressed. Therefore, we concluded the providers systems and processes for monitoring and assessing the safety and quality of the service were effective.

The hospice was part of a managed clinical network working with other palliative care providers across Bradford, Airedale, Wharfedale and Craven. The aim of this partnership working was to improve the experiences of people who used palliative care services across the district. As part of the managed clinical network the hospice took part in a 'Last year of life' project which won a BMJ (British Medical Journal) award in 2015.